CENTERS F	OR MEDICARE & MEDICAID SERVICES			"A" FORM	
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY	
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:	
FOR SNFs AND) NFs	345218	B. WING	8/18/2017	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, C	ITY, STATE, ZIP CODE		
MARY GRAN NURSING CENTER			120 SOUTHWOOD DRIVE BOX 379		
		CLINTON, NC			
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	TIES			
F 463	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH				
	(g) Resident Call System				
	The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -				
	(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to assure that all portions of the call bell system were functioning properly for 1 of 40 sampled residents. (Resident #116)				
	Findings included:				
	The call bell alarm log dated 07/27/2017 for resident #116's room indicated it passed inspection.				
	During an observation on 08/15/2017 at 9:17 A.M., resident #116 in bed with head of bed elevated alert and oriented to self, clean, neat appearance, eating breakfast. The call bell or hand bell was not within reach and could not be seen on the bed, on the floor or connected to the wall outlet. The light was not on over residents 'room door and the alarm was not sounding.				
	08/15/2017 at 9:19 A.M., the Nursing Assistant (NA) #1 entered the room and was made aware the call bell was not within reach. NA #1 stated she didn't know what happened to the call bell. NA #1 also stated it was overlooked when she checked the resident at the beginning of the shift. NA #1 looked in the bed, under the bed and in the side table. NA #1 stated she couldn't find the call bell wire.				
	08/15/2017 at 9:21 A.M., Nurse #1 was made aware that the call bell was not within reach. Nurse #1 stated she didn't know where the call bell wire could be. Nurse #1 looked for the call bell on the bed, under bed, side dresser and closet. Nurse #1 also stated she would get maintenance to get one right now. The Maintenance Supervisor arrived with a call bell wire and attached it to the wall and tested it to assure it was working.				
	During an interview with the Maintenance Supervisor on 08/16/2017 at 3:59 P.M., the Maintenance Supervisor stated if the call bell was detached from the wall socket it would alarm.				
	During an interview with the Administrator on 08/17/2017 at 11:30 A.M., the Administrator stated his expectations were for all the residents to have accessible call bells.				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents